



Health Alliance Medical Plans  
Attn: Illinois Pre-existing  
Insurance Plan (IPXP)  
301 S. Vine St.  
Urbana, IL 61801-3347  
1-877-210-9167

## Qualifying Pre-existing Medical Condition Certification Form

Please print all information.

The "Physician's Certification" section of this form must be completed by your physician.  
This completed form must be returned with your application.

Name: \_\_\_\_\_  
*last*                    *first*                    *middle*

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Day-Time Telephone Number: \_\_\_\_\_

Primary Applicant's Signature: \_\_\_\_\_ Date (MM/DD/YY): \_\_\_\_\_

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date (MM/DD/YY): \_\_\_\_\_  
(if applicant is under age 18 or legally incompetent)

### Physician's Certification

Physician's Name: \_\_\_\_\_  
*last*                    *first*                    *middle*

Physician's NPI: \_\_\_\_\_ The person has been my patient since (MM/DD/YY): \_\_\_\_\_

**Physician: Please indicate below, the patient's primary pre-existing medical condition.**

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Physician's Signature: \_\_\_\_\_ Date (MM/DD/YY): \_\_\_\_\_